

Clinical Lessons Learned from EPICONS

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Acknowledgements

- Michael Bell
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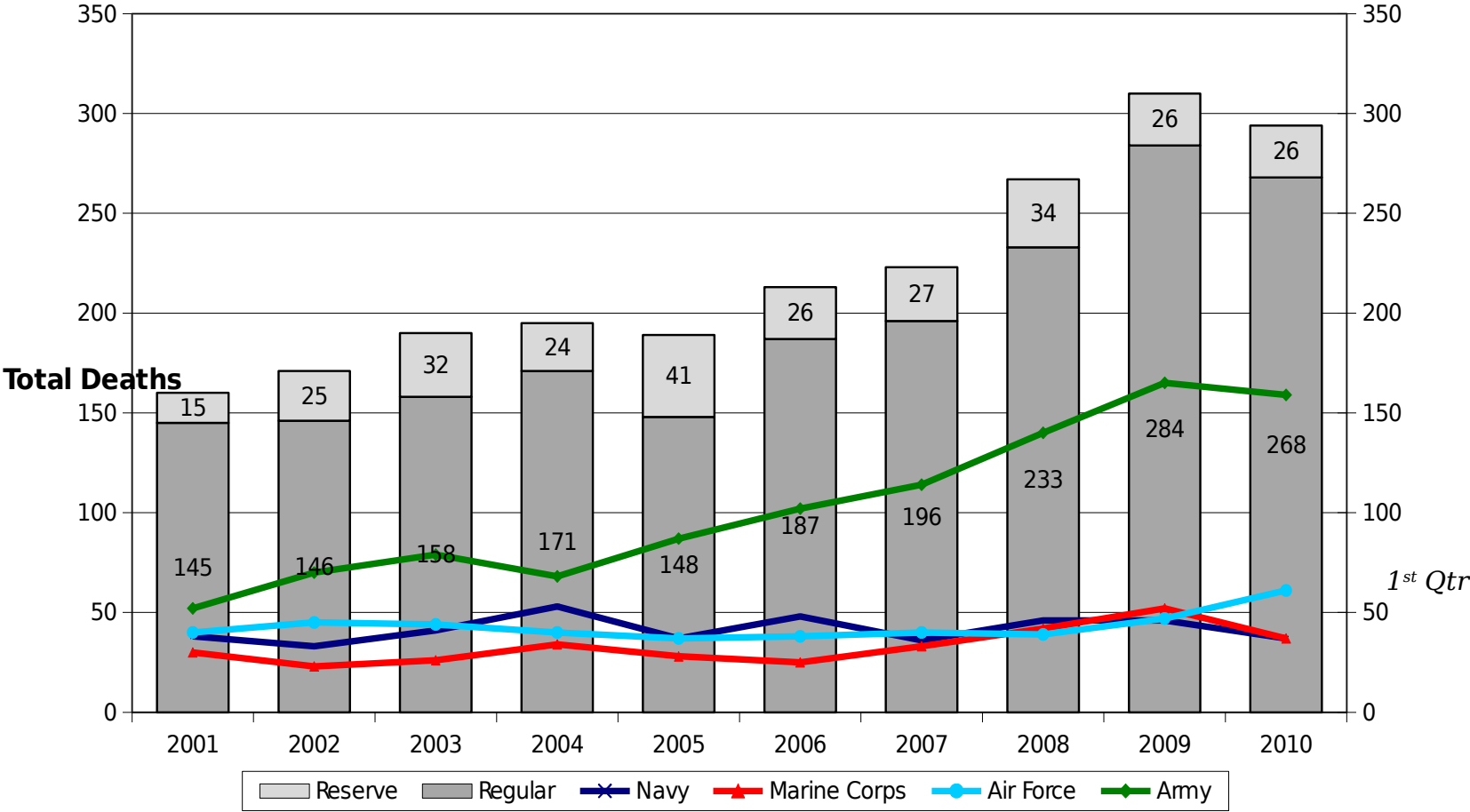
BRIEFING OUTLINE

PURPOSE: To provide an overview of the EPICON (Epidemiological Consultation) process, and clinical lessons learned from EPICONS.

1. Background and History
2. A Few Statistics
3. What is an EPICON ?
4. Lessons from Individual EPICONS
5. Basics of Doing EPICONS
6. Staff Assistance Visits/SSART-SRT
7. Conclusion
8. Way Ahead

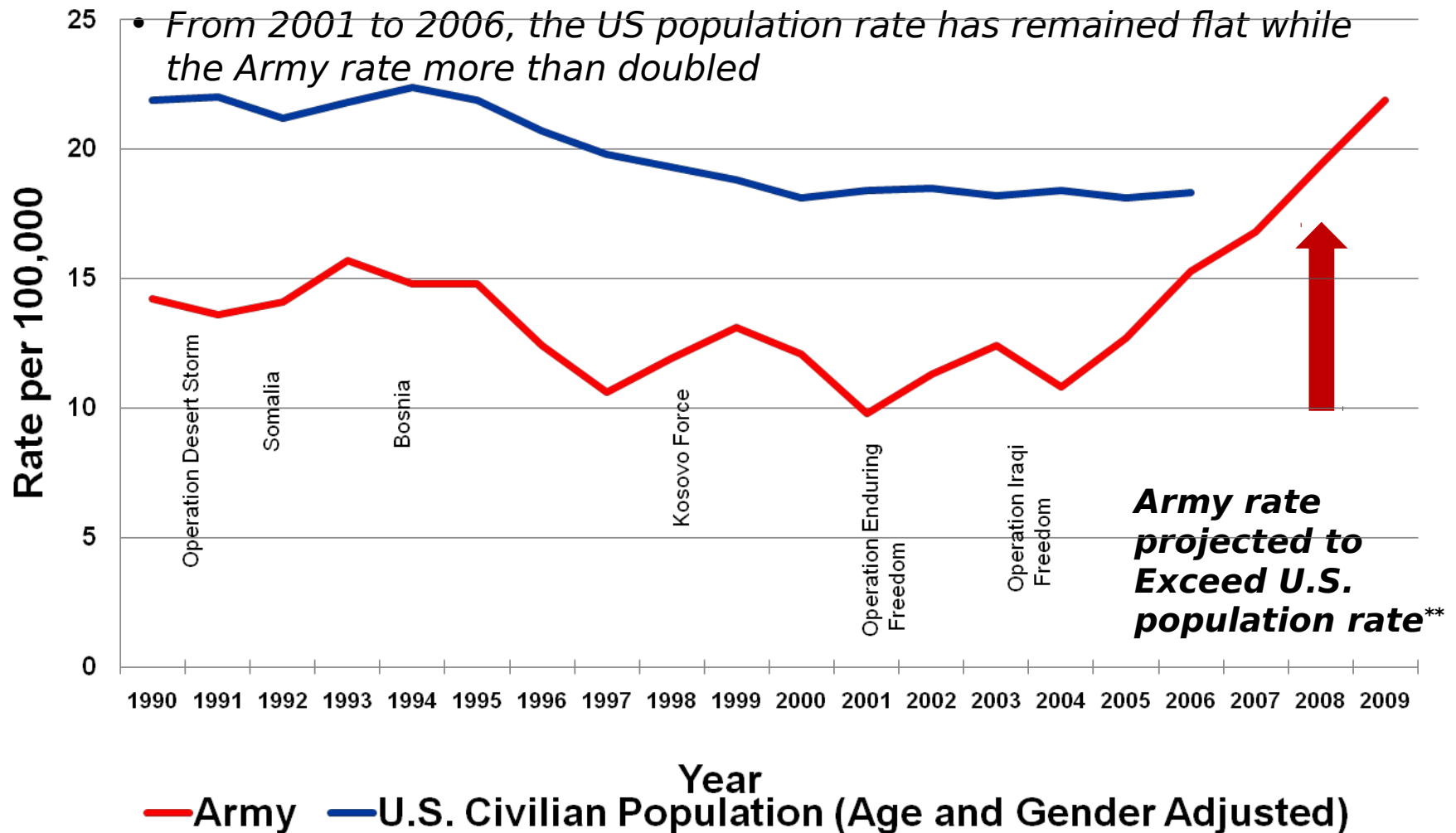
DoD Suicide Deaths/Rates Branch CY 2001-2010

Confirmed and Suspected Active Duty Military Suicides by Component, Branch, and Year
January 1, 2001 - December 31, 2010 (as of 2/7/2011)



Suicide Rates from 1990-2009

- Historically, the US Army rate has been lower than the US population rate
- Both populations experienced a downward trend from the mid-90's to 2001
- From 2001 to 2006, the US population rate has remained flat while the Army rate more than doubled



SOURCE: CDC/NCHS, National Vital Statistics System (civilian data). G1 (Army data)

Prepared by: USAPHC-P BSHOP

**Comparable civilian rates were only available from 1990-2006

Common Behavioral Health EPICON Themes

Theme	Ft Leonard Wood 2001 (suicide)	Ft Bragg 2002 (homicide)	Ft Riley 2005 (suicide)	Ft Hood 2006 (suicide)	Ft Campbell 2008 (suicide)	Ft Carson 2009 (homicide)
INDIVIDUAL RISK FACTORS						
Deployment: length, multiple, unpredictability		X	X	X	X	
Combat Intensity						X
Family Separation - Relationship Stress - Lack of Support		X	X	X	X	X
Increased violence against persons including spouse/family		X	X	X	X	X
Increased use of alcohol and drugs, and related offenses			X	X	X	X
Previous gestures/attempts/BH contact	X	X	X	X	X	X
Manipulating - Malingering	X		X		X	X
Legal and Financial Issues		X	X	X	X	X
History of misconduct						X
SYSTEMS ISSUES						
Stigma: personal, peer, leadership, career		X	X	X	X	X
Poor Service Delivery for dependents		X	X	X		

Background

- Behavioral Health EPICONS review target events in the context of the social-behavioral status of an organization/community.
 - Examining multiple measures (i.e.: burden of disease, social support, psychiatric symptoms, Soldier and leader perceptions, barriers to care) is necessary to discern risk factors and potential mitigating strategies.
 - Examining multiple sources and types of data is necessary to capture and characterize the social-behavioral environment
-

Ft. Leonard Wood

- 2001
- Recruit training base
- Suicides prior to 9/11
- Two suicides in recruits
 - One on “suicide watch”
- Recruit suicides fairly unusual
 - Gestures common
- Led to increased focus on moment of truth
- May have contributed to increased attrition in following years
- Renewed focus on “what is suicide watch”
- Low publicity

Ft. Bragg

- 2002 at Ft. Bragg
- Index cases: 2 murders of wives, two murder-suicides of husband and wives
 - 3 were special forces
- Index cases not known to mental health
- 12 man team from Army did the EPICON
- Interviews, focus groups, record review
- Issues: rapid return from theater, access to care, stigma
- Led to Deployment Cycle Support, Battlemind
- High visibility

Unidentified Agency

- None of the index cases known to mental health
- Common theme: concern about security clearance
- Led to: care available within walls (EAP model)
- Eventually: security clearance revisions
 - Revision of Question 21

Ft. Riley

- 2005
- One of first observations of upward trend in suicides in FORSCOM unit
- Challenges of change in mission and command structure
 - Big Red One
- Few resources available for relationship issues
- “Gatekeepers” not attuned to suicide issues
- Weapons use common
- Update: marriage therapists added

Ft. Hood

- 2005
- High optemo, transitions in leadership
- Fragmentation of care (ASAP, mental health)
- Elevated Suicide rate often accompanied by elevated rates of violence
- Access to weapons
- Emerging tend: more Soldiers seen by mental health, but getting to mental health does not prevent them from killing themselves

Ft. Campbell

- 2007
- Persistently Elevated suicide rate
- Effort led by CHPPM (COL Brewster, LTC Bell)
- Soldier surveys, attitudes about stigma
- High optemo, transitions in leadership
- Fragmentation of care (ASAP, mental health)
- Elevated Suicide rate often accompanied by elevated rates of violence
- Access to weapons
- Emerging tend: more Soldiers seen by mental health, but getting to mental health does not prevent them from killing themselves

Ft. Carson

- 2008
- Homicides central focus
- Suicides, sexual assaults also elevated
- Index units had heavy deployment experience
 - Not necessarily index cases
- Challenges of doing EPICONS as other investigations ongoing
- High media visibility

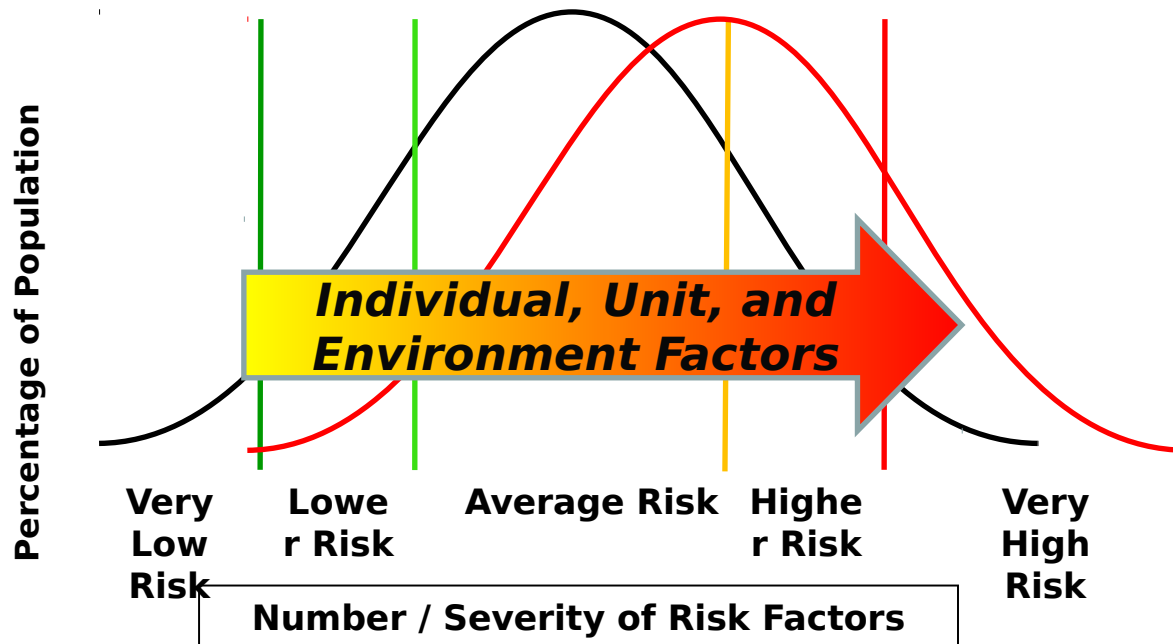
Stigma

- Four types of stigma generally seen: career, leadership, peer-to-peer, and personal
- Stigma was reported differently across rank groups; lower enlisted were more concerned about peer and self-perceptions, senior enlisted were most concerned about their career and perceived leadership abilities

Career	Leadership	Peer-to-Peer	Personal
On permanent record, effects future promotion and employment	Some old school, senior NCOs, and early promoted NCOs create/maintain stigma	Peer stigma is the worst	Weak, isolated, embarrassed
End career, lose retirement	More stigma for senior enlisted, others think they can't lead, fear of effecting retirement	More stigma if never deployed	Profile makes them feel worthless
Lose security clearance	Many squad/platoon leaders don't support	Treated differently, Ridiculed	Pride/Denial
"Boarded out" rather than rehabilitated	Treated differently; doubt 'warrior' abilities; ridicule those with a profile	Gossiped about/Perceived faking	Don't want to be viewed as a "bad" soldier

Causal Factors for Suicidal Behavior and other Violence Among Soldiers

- Multiple individual, unit, and community factors appear to have converged to shift the population risk to the right



Facts

Individual

- Criminality/Misconduct
- Alcohol / Drugs
- BH Issues
(untreated/under-treated)

Unit

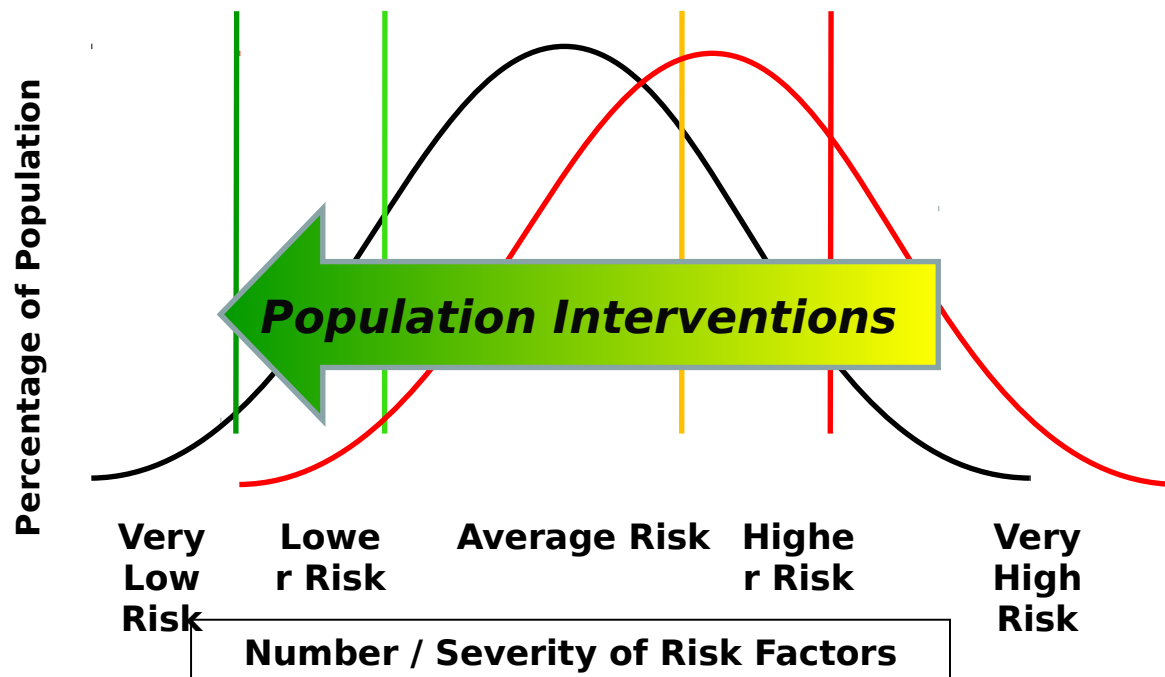
- Turnover
- Leadership (Stigma)
- Training / Skills

Environment

- Turbulence
- Family Stress / Deployment
- Community
- Stigma

Strategies to Decrease Suicidal Behavior and Violence

- While it is important to identify and help individual Soldiers, the biggest impact will come from programs that shift the overall population risk back to the left
- Effective medical treatment can prevent individuals from increasing in risk or decrease their risk, but it cannot shift overall population risk very much



Army Campaign Plan:

- Health Promotion, Risk Reduction, and Suicide Prevention
- Increase Resiliency
- Decrease Alcohol/Drug Abuse
- Decrease Untreated/Undertreated BH
- Decrease Stigma to Seeking Care
- Decrease Relationship/Family Problems
- Decrease Legal/Financial Issues

Installation:

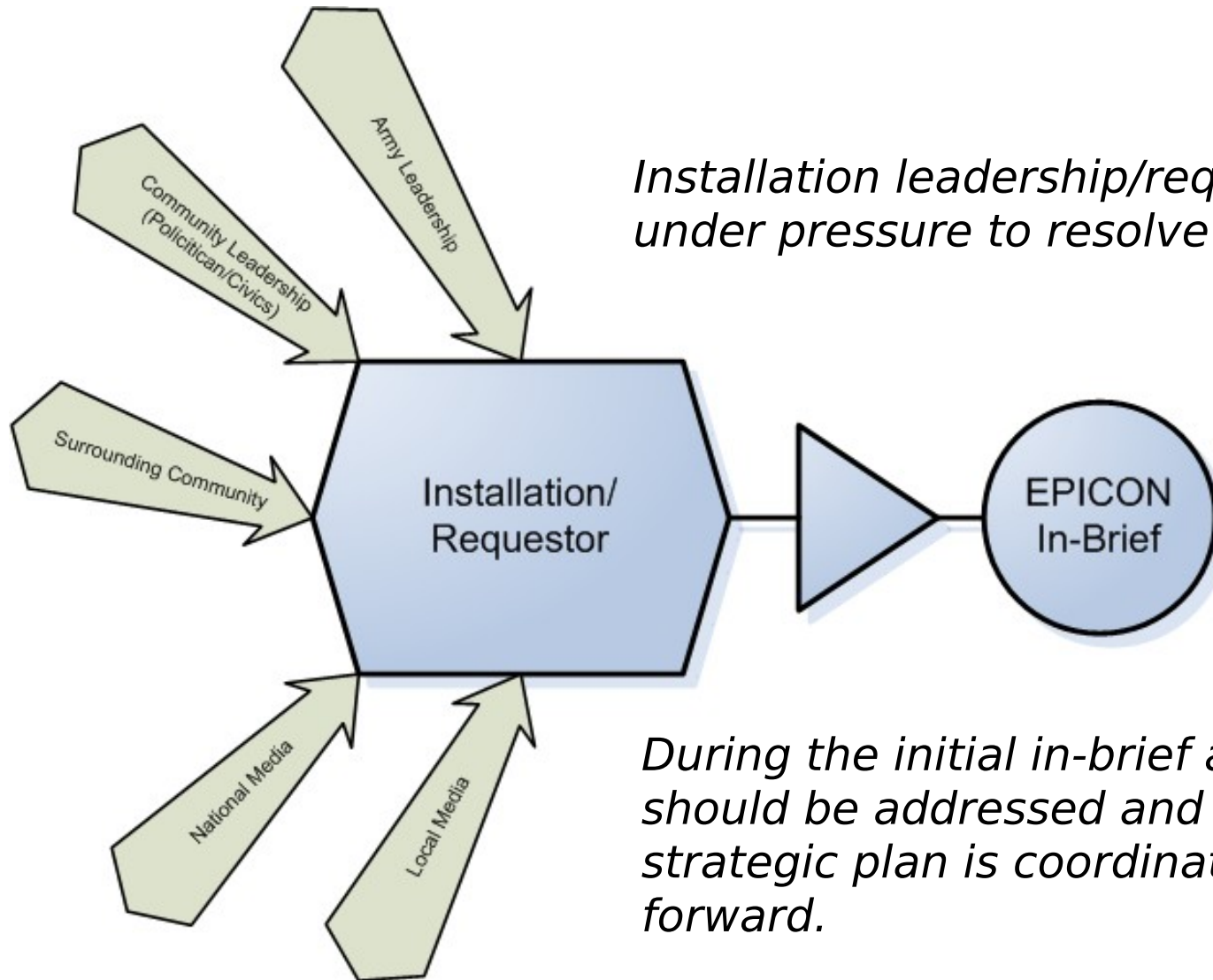
- Reintegration (Plus)
 - Mobile Behavioral Health Teams
 - Mental Toughness Training
 - Resiliency Training
 - Military Family Life Consultants
 - Decompression Reintegration
 - Warrior Adventure Quest
- Consistent Stigma Reduction themes

Tasking

Specific types of BH-EPICON taskings can include:

- Identification of risk factors:
 - Among index cases of interest
 - Within a unit/organization (population characterization)
- Examination of rates and trends in a specific subset of the Army population and comparison groups.
- Assessment of adequacy of the BH programs and resources.
- Recommend strategies to reduce the installation's incidence of the event in question and/or improve functioning of BH programs.

Managing Local Leadership and Public Concerns



Installation leadership/requestor may be under pressure to resolve the problem.

During the initial in-brief all concerns should be addressed and a mutual strategic plan is coordinated for moving forward.

*PAO concerns **MUST** be addressed.*

Potential Guiding Questions

- Are there commonalities between the index cases (i.e. Suicides, Homicides, etc.)?
 - What is different about the index cases and their units from other Soldiers (or units) on the installation?
 - Is this Installation different from other comparable installations or from the Army as a whole?
 - Does this Installation have adequate BH resources and social support programs to meet current and anticipated demands?
 - Are there barriers to care or problems with BH and social support programs that can be reduced?
 - Other specific Army leadership requests/questions.
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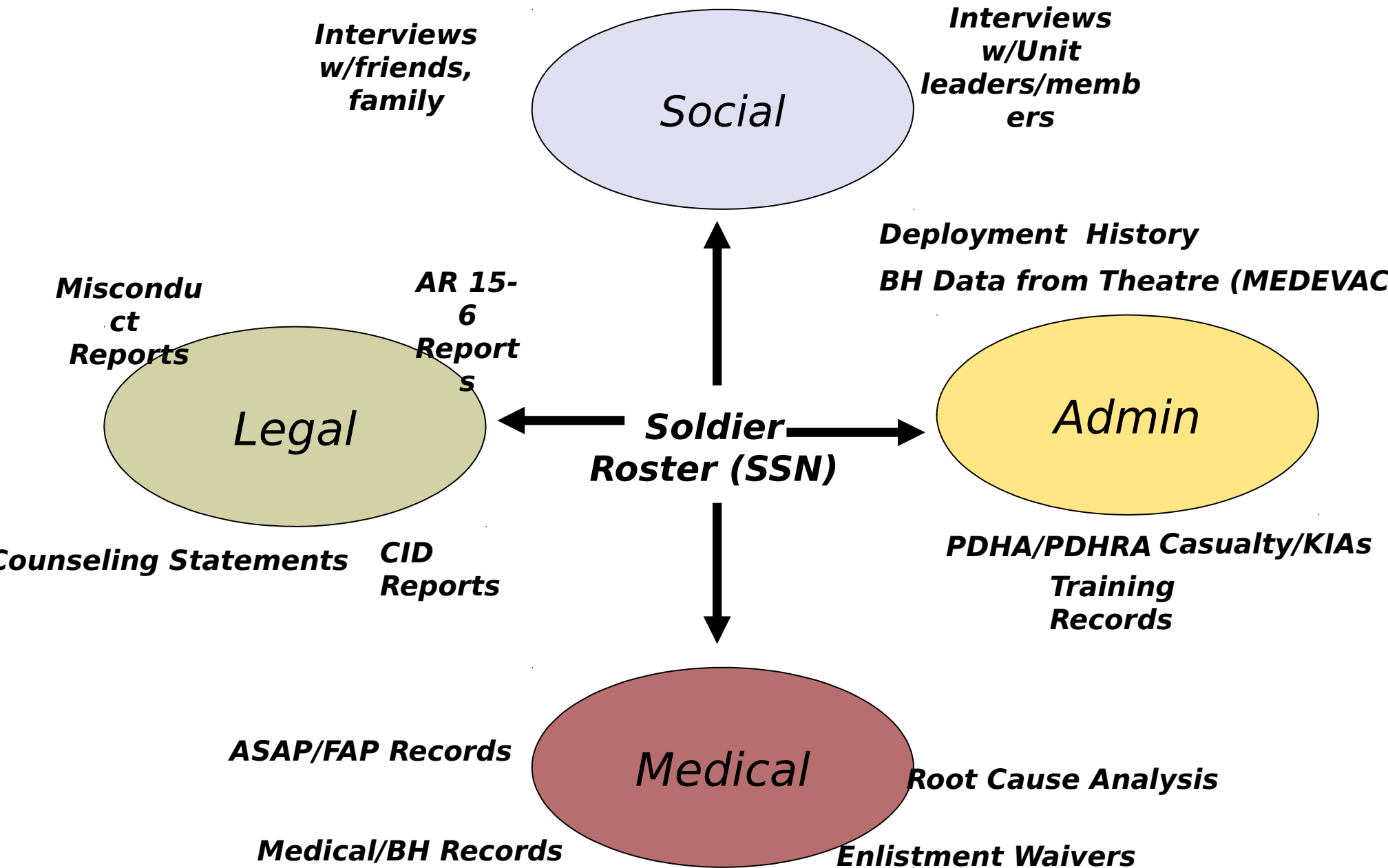
Data Types and Sources

- **There are two categories of data:**
 - *Existing:* That is, data that has already been collected.
 - *Non-existent:* Data which you will have to generate.
 - **These data come in two types:**
 - *Quantitative:* Numerical data that can be used to compare within and between people/units/groups/installations/etc.
 - *Qualitative:* Non-numerical, descriptive data drawn from interviews, texts, and observations that help form hypotheses or increase understanding (“fleshes out the numbers”).
 - **Data generally relate to two different “units of scale:”**
 - Individuals: Index cases.
 - Populations: Units, Installations, groups of individuals, etc.
-

Data Sources: Existing Data

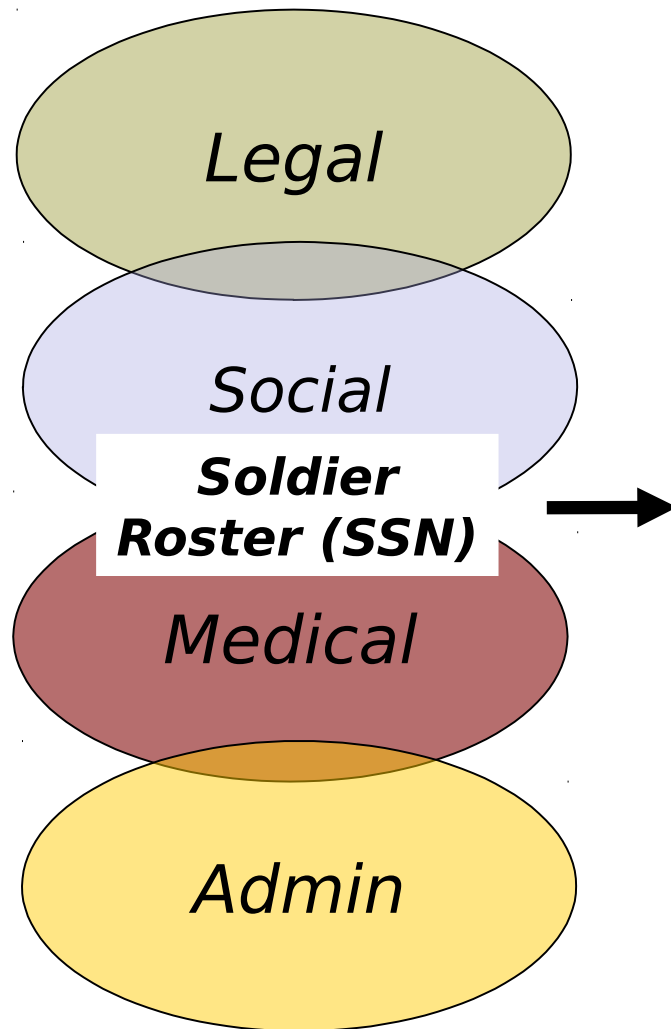
- Large quantities of diverse data are often captured by administrative databases for purposes other than public health research – but can be very useful.
 - Types of data include:
 - Data for individual Soldiers (i.e. AFHSC)
 - Population level data for installations (i.e. DMED).
 - Most data is obtainable for public health practice with proper authority and with proper precautions to minimize Privacy Act or HIPAA concerns.
 - If time exists, preliminary analysis of this information can provide context to the investigations prior to deploying to the installation.
-

Existing Individual Data Sources



Existing Population Data Sources

Epidemiologists can link numerous types of individual data using SSNs



Allows for characterization of the individuals within the population of interest and any representative comparable population



- *Generates further hypotheses*
- *Highlights data limitations*
- *Aids in developing instruments (i.e. surveys, focus group/interview questions)*

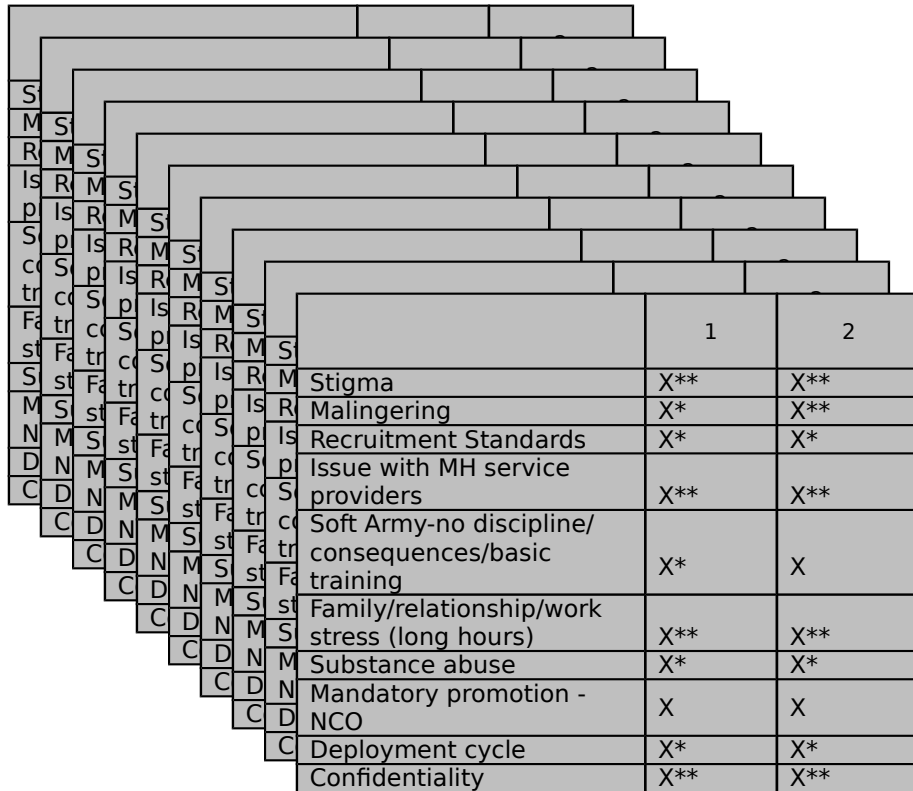
Non-existing Data Sources

- If insufficient data exists to answer the guiding questions related to population trends, it may be necessary to gather additional data. Possible methods include:
 - Interviewing key population / subpopulation members
 - Conducting focus groups (where there are large numbers of key population members, and you need a sample)
 - Conducting written or telephone surveys.
- Methods must be correlated to compliment one another
 - Quantitative data (surveys and “quantitized” qualitative data) provide numbers for comparison – leaders love numbers.
 - Qualitative data (Interviews / Focus Groups) provide depth and understanding to the numbers.
- For both data types, proper sampling and systematic collection of data is critical to valid results that leaders will be willing to believe.

Data Sources: Interviews

- **Key informants to be interviewed may include:**
 - Commanders/Leaders
 - Behavioral Health personnel
 - Other relevant clinical personnel
 - Community services personnel
 - Those involved in index cases
 - In some cases the actual index cases themselves
- **Interviews provide contextual/anecdotal information:**
 - Increases understanding of the event(s) and processes
 - May result in identification of additional data sources
 - May result in the development of additional hypotheses
 - May be supported/refuted by other data gathered

Data Sources: Focus Groups



	1	2
Stigma	X**	X**
Malingering	X*	X**
Recruitment Standards	X*	X*
Issue with MH service providers	X**	X**
Soft Army-no discipline/consequences/basic training	X*	X
Family/relationship/work stress (long hours)	X**	X**
Substance abuse	X*	X*
Mandatory promotion - NCO	X	X
Deployment cycle	X*	X*
Confidentiality	X**	X**

Qualitative data is collected consistently across all focus groups and is then compiled into a central data system.



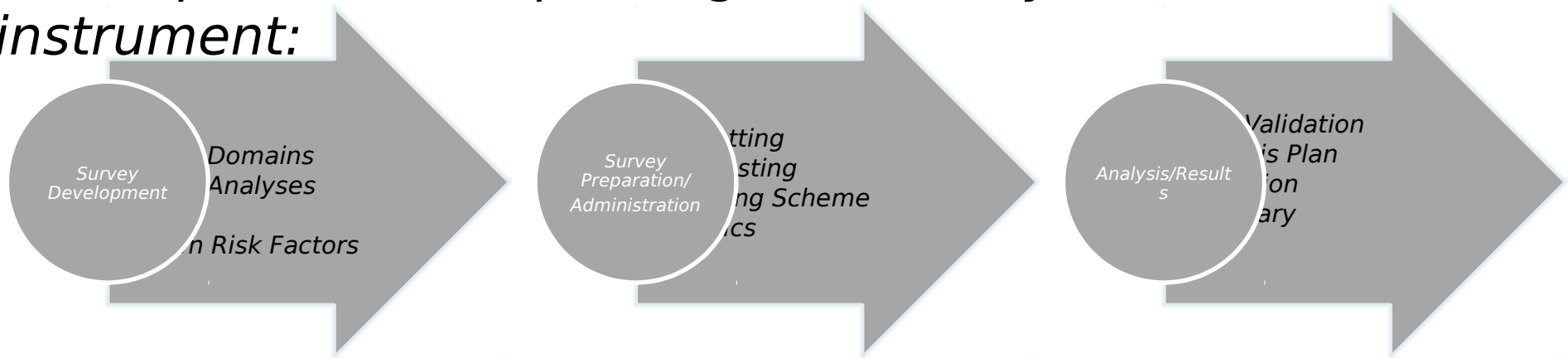
	E1-4	E5-6	E7+
Stigma	X**	X**	X**
Malingering	X*	X**	X*
Recruitment Standards	X*	X*	X*
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Family/relationship/work stress (long hours)	X**	X**	X*
Substance abuse	X*	X*	X



- Qualitative data analysis leads to patterns, trends and emerging themes.*
- These generates further hypotheses...*
- Because time is always short, Qualitative and Quantitative efforts run concurrently must be coordinated to compliment each other.*

Data Sources: Survey

Development of unique targeted survey instrument:



- *When possible, incorporate existing validated scales and items for stronger validity, acceptability, and comparability*

- *Paper Forms and scanning software has been used successfully in the past.*
- *Web-based format may be used in the future (although it limits administration options).*

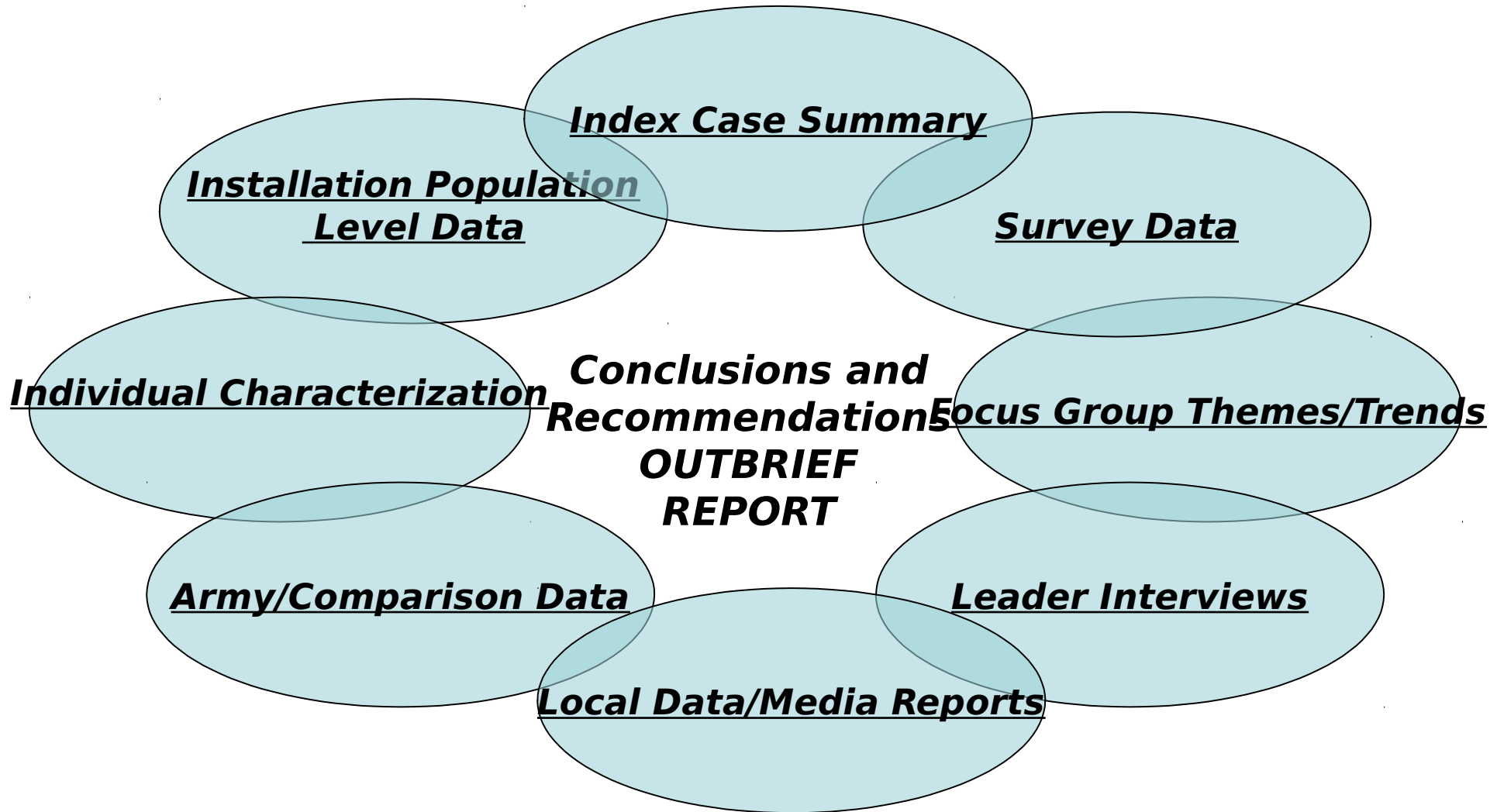
- *Survey results are summarized and incorporated with the results from other analyses.*
- *Hypotheses stemming from administrative analyses, focus groups or interviews are answered, if*

Data Sources: Civilian Media

Retrieval and assessment of Civilian media:

- Civilian media can sometimes provide rich contextual information pertaining to index events or index subjects.
- Helpful if data is not otherwise available or well-captured.
- Where relevant, Civilian media can be used to make comparisons between similar events at other installations or in the surrounding community.
- Can offer insight into larger environmental influences.
- Can offer insight into how index events are being viewed publicly at the local and national levels.
- May be “sensationally” biased or poorly-researched.
- Discretion must be used (limitations should be noted).

Summary of EPICON Findings



Staff Assistance Visits

- Smaller team and tighter mission than EPICON
 - Iraq
 - Ft. Stewart
 - Ft. Rucker
- Interview same populations
 - Soldiers, leaders, medical, chaplains, consider law enforcement
- More subjective
- Less work (no focus groups or surveys)
- Lower media visibility

Specialized Suicide Response Augmentation Team

- Developed Spring 2010
- Lead is Army G-1
- Visit to US Recruiting Command
- Challenges of dispersed population
- Team visit highlighted positive changes since Houston Recruiting Battalion

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Increased use of alcohol and drugs, and related offenses			X	X	X	X
Previous gestures/attempts/BH contact	X	X	X	X	X	X
Manipulating - Malingering	X		X		X	X
Legal and Financial Issues		X	X	X	X	X
History of misconduct						X
SYSTEMS ISSUES						
Stigma: personal, peer, leadership, career		X	X	X	X	X
Poor Service Delivery for dependents		X	X	X		

Questions/Discussion

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Back-Up Slides

Planning an EPICON

*The EPICON Plan must be reviewed and approved by Requestor & EPICON team
(Becomes the informal “contract”)*

*Development of
Guiding Questions*

*Development of
Epidemiologic
Methodological
Approach*

*Data Requirements
Identified*

- *KEY TO SUCCESS!!!*
- *Defines the scope of the EPICON mission*
- *Requires political and strategic input*
- *Must consider METT-TC*

- *Uses multiple research or evaluation methods to triangulate on answers to the guiding questions*
- *Determines what populations/subpopulations need to be sampled*
- *Team task-organizes to focus on various methods*

- *Identify existing databases and record systems*
- *Carefully choose/craft scales, instruments, and questions for surveys and/or interview schedules*
- *Cross-walk all items and methods to ensure a coordinated effort focused on answering*

BH-EPICON Team Composition

- Picking the right mix of expertise is critical at all stages of the EPICON. This mix may change at each stage.*
- Minimally, experts should be brought in early in the planning and review final product.*

BH-EPICON Military and Civilian Subject Matter Experts

Physician Epidemiologist	Qualitative Researcher
Social Epidemiologist	Operations Officer
Social Worker	Risk Communication
Psychiatric Epidemiologist	IMCOM HQ Rep
Public Health Nurse	HQDA G1 Rep
Chaplain	Local Preventive Medicine Rep
Forensic Psychiatrist	Local CID Rep
Forensic Psychologist	PAO Rep
Other Behavioral Health Support	Survey/Interview Personnel

Initiating an EPICON Tasker

- Given an apparent behavioral health issue, local leadership may initially form a local task force/committee to examine the problem more closely.
- Problems warranting a broader investigation or specific subject matter expertise may lend itself to an EPICON.
- The local requestor will coordinate with the Office of the Surgeon General (OTSG) and the US Army Center for Health Promotion and Preventive Medicine (USACHPPM).
- The USACHPPM Directorate of Epidemiology and Disease Surveillance can stand-up the Behavioral

Out-briefs and Reports

- **The Strategic Communications (STRATCOM) plan** must be negotiated with the requestor, etc. at the beginning of the EPICON. Included in the STRATCOM:
 - In-Progress Review (IPR) schedule and expectations
 - Who else may be briefed (and on what information)
 - Who has public release authority (usually the requestor, but may be claimed by higher command, DA, or DOD)
 - Who/what (if anything) will be released to the public about the existence and/or purpose of the EPICON
 - Who will need to be briefed on the findings/recommendations
 - What the order of those briefings should be
- **Where possible, not only should individuals be**

Following Up an EPICON

- Requestor defines the process to review, approve, and ensure acceptable recommendations are implemented.
 - The OTSG/MEDCOM should assist with providing support, where necessary.
 - Recommendations with broader implications for the Army/DOD must be staffed through senior Army/DOD leadership for approval, implementation, and public release.
 - Where possible, not only should individuals be given confidentiality, but so should units and organizations.
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Final Thoughts

- Don't assume requestor and EPICON team are on the same page. Be sure to agree on specific guiding questions and mission scope up front.
- Expectation and time management are critical – for self and others.
- Ensure you have command backing and that the subordinate leaders/players are aware you have command support.
- Start with the end in mind □ the Report/Briefing. Work it from the very start of the mission. Visualize the final product and plug things in.
- You are only as credible as your data. Don't make findings or recommendations your data don't support (let alone contradict).
- Every recommendation must come from at least one finding, and every finding must have a recommendation (even if it's to gather more data).
- Don't underestimate the power of politics and/or the media – at